CAMPYLOBACTERIOSIS CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health State Form 49685 (R2/1-05)

DIRECTIONS - PLEASE READ BEFO	RE YOU BEGIN:										
1 Print firmly and neatly. 3 Fill in	circles like this; • 4	Print capital letters only § Please complete									
	ke this: 💢 🦸	and numbers completely all items on form. Date format:									
black ink. Mark	mistakes like this:	inside boxes. $ A 2 C 3$									
Section 1. Demographic Information											
Last Name											
	1 1 1 1 1 1										
First Name MI Phone Number											
Number 9 Street Address											
Number & Street Address											
City		State ZIP Code									
County		Date of Birth Age									
Race:	E	thnicity: Is Age in									
Asian Black or African American	O White	Hispanic or Latino O Not Hispanic or Latino O Unknown day/mo/yr?									
O American Indian or Alaska Native O Unknown O Months											
O Native Hawaiian or Other Pacific Islander) Male O Female O Unknown O Years									
Occupation Phone of Employer/School/Day Care											
Name of O Employer O School											
Address of Employer/School/Day Car	е										
City		State ZIP Code									
City	Section 2 Cl	State ZIP Code inical Information									
Symptoms:	occion 2. or	Source of Positive Specimen:									
○ Fever (degrees)	1 1 1/1 1 1	∫									
O Diarrhea	Date of Onset	○ Blood									
O Blood in Stool	Duration of Symptom	O Urine									
O Abdominal Cramps		Other, specify:									
O Nausea	Date First Positive Sp	/ L L L L L L L L L L L L L L L L L L L									
○ Vomiting											
O Gas											
Other, specify:											
Culture Results: ○ Campylobacter jejuni ○ Campyloba	acter coli O No Positiv	e Culture 〇 Other, specify:									

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Was Campylobacter strain resistant to any antibiotics? O Yes O No O Unknown If Yes, antibiotic:										
○ Yes ○ No ○ Unknown If Yes, antibiotic:										
Physician/Hospital that Collected Specimen										
Physician/Hospital Address										
City State ZIP Code										
Physician/Hospital Phone										
Was the patient hospitalized? If Yes, admission date:										
○ Yes ○ No Discharge date: / /										
~ / /										
Hospital: _										
Wee the noticet treated with outilistics often are 20.										
Was the patient treated with antibiotics after onset? O Yes O No O Unknown										
If Yes, antibiotic										
Date started Date ended										
Did the patient die? O Yes O No										
Section 3. Epidemiologic Information										
List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.										
1										
1. <u> </u>										
1. <u> </u>										
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1										
1										
1. Establishment Name Address Foods Eaten (list) Date 2. Establishment Name Address										
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1. Establishment Name Address Foods Eaten (list) Date 2. Establishment Name Address										
1. Establishment Name Address Foods Eaten (list) Date 2. Establishment Name Address Foods Eaten (list) Date 3.										
1. Establishment Name Address Foods Eaten (list) Date 2. Establishment Name Address Date										
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1. Establishment Name Address Foods Eaten (list) Date 2. Establishment Name Address Foods Eaten (list) Date 3.										
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4.	1 1 1	1 1 1	1 1	1 1	1 1	1 1	1	1	1	1 1	1	1 1	1 1 1
Establishment Name	Э		' '	' '		'	•	•	•		•	, ,	
Address											,		,
									IJ Ĺ		/ _	/	′ ليا
Foods Eaten (list)		_								ate			
List all group gatherin	gs where fo	od was ser	ved that	the patie	ent atten	ded duri	ng the	5 day	s prior	to illne	ess or	nset.	
1.	1 1 1	1 1 1	1 1	1 1	1 1	1 1	1 1	1	1	1 1	1	1 1	1 1 1
Type of Gathering													
	1 1 1												
Responsible Person	1					,		,					
						」/ ∟		/ ∟					
Phone Number			No. of	Persons	Date								
2.	1 1 1	1 1 1	1 1	1 1	1 1	1 1	1 1	1	1	l I	1	1 1	1 1 1
Type of Gathering							•	•	•	•	•		
	1 1 1												
Responsible Person	1												
			Ш			」/ ∟		/ ∟	Ш				
Phone Number			No. of	Persons	Date								
List all stores where p	atient boug	ht groceries	s that we	re consu	ımed du	ring the	5 days	prior	to illne	ss ons	et.		
Store Name:			Street A	\ddress:					[Date:			
	1 1 1	1 1 1	1 1	1 1	1 1	1 1	1 1	1	1 11	ı	1/1	1 1.	/, , ,
	1 1 1		1 1	1 1	1 1		1 1	i		ı	//		/
											'		<u>'</u>
											<i> </i>		′,└┴┴
	1 1 1												/
Indicate whether the	natient con	sumed the	following	ı foods o	r hevera	aes duri	na the	5 day	s nrinr	to illne	ee or	nset	
Food Item:	Date Con		TOHOWING		d Name:	goo dan	ng the	-	-	Place F			
O Chicken			/		ı Name.	1 1	1 1	110	1 1	1 10001	ui Cili	ı ı	1 1 1
○ Turkey		/	/		1 1	1 1	1 1		1 1	1 1		1 1	
O Cornish hen		/	/				1 1		1 1		1	1 1	
O Unpasteurized milk		/	/	_				_					
O Powdered (dry) milk		′	/ <u> </u>				1						
Beef		′, 📖	′										
		′, 📖	/ _/										
O Pork		/	<i>',</i>						1 1				
○ Seafood	1 1 1	I + + +	I + +	11 1	1 1	1 1	1 1	1.1	1 1	1 1	1	1 1	1 1 1

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Section 4. Risk Factors (continued) During the 5 days prior to illness onset, did the patient: Handle/Consume raw or undercooked poultry? O Yes O No O Unknown If Yes, date: Consume unpasteurized milk or milk products? O Yes O No O Unknown If Yes, date: Have contact with pets? O Yes O No O Unknown If Yes, date: Type of animal: Location: Have any of the pets had diarrhea? O Yes O No O Unknown Have contact with wild or exotic birds? If Yes, date: _____/ ____/ _____/ O Yes O No O Unknown Type of bird: Have contact with poultry or other livestock? If Yes, date: | | | / | | | / | | O Yes O No O Unknown Type of animal: Location: Did any of the animals have or develop diarrhea? O Yes O No O Unknown Drink or have exposure to untreated surface water (including lakes, streams)? If Yes, date: | | | / | | | / | | O Yes O No O Unknown Location: Go swimming? O No O Yes O Unknown If Yes, date: Location: Travel outside of Indiana? O Yes O No O Unknown If Yes, where

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Section 4. Risk Factors (continued) Has the patient had contact with anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain? O Yes O No O Unknown If Yes, name: Phone number: Onset date: Relationship: Was this person exposed to any of the same commercial food establishments, group gatherings, or travel history as the patient? O Yes O No O Unknown If Yes, describe Section 5. Comments/Follow-up Comments: **Investigator Name** Agency **Phone Number**